

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: May 1, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopic subacromial decompression, right shoulder arthroscopic glenohumeral debridement, assistant surgeon, right shoulder arthroscopic synovectomy, complete, and right shoulder mini-open rotator cuff repair.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is certified by the American Board of Orthopaedic Surgeons with over 42 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his right shoulder on xx/xx/xx.

03/08/12: An office visit indicated that the claimant was status post right rotator cuff repair and resection of adhesions/suture material. It was also noted that he had recently undergone cervical disc replacement and had marked improvement in his right upper extremity pain. It was impression that a lot of his weakness was due to his neurological problem. He was to advance in strengthening exercises as tolerated.

06/08/12: MRI Right Shoulder report. IMPRESSION: Moderate hypertrophic longitudinal partial tearing in the bicipital tendon as it becomes intra-articular near

the top of the bicipital groove. No SLAP lesion. Evidence of previous rotator cuff tendon repair probably in the distal supraspinatus tendon. Mild tendinosis and perhaps some mild partial tearing on the articular surface with the predominant abnormality tendinosis. Normal infraspinatus, teres minor, and subscapularis tendons. Fluid in the acromioclavicular joint with probable partial resection for decompression of the supraspinatus outlet. Small amount of debris within the fluid as well. No acute osseous abnormality. No significant narrowing of the supraspinatus outlet. Normal labrum.

08/08/12: Operative report. POSTOPERATIVE DIAGNOSIS: Recurrent high-grade partial-thickness rotator cuff tear. Impingement. Glenohumeral synovitis with hypertrophy and partial tearing of long head of biceps tendon. Labral tear. PROCEDURES PERFORMED: Arthroscopic glenohumeral debridement, extensive, right shoulder. Arthroscopic glenohumeral synovectomy with tenotomy of long head of biceps tendon, right shoulder. Revision surgery arthroscopic subacromial decompression and bursectomy, right shoulder. Revision surgery arthroscopic assisted (mini-open) rotator cuff repair, right shoulder.

03/18/13: The claimant was evaluated. It was noted that he continued to participate in postoperative rehabilitation and was doing quite well. It was recommended that he continue with his home exercise program and return for a follow-up visit on June 17.

11/25/13: The claimant was evaluated. It was noted that in August, he developed right shoulder pain without any specific injury. He noticed that he noticed pain when he tried to elevate his arm. He had a cortisone injection by his pain management doctor on "Friday." On exam of the right shoulder, impingement signs were positive. Supraspinatus strength was 5/5. External rotation strength was 5/5. Deltoid, biceps, and internal rotation strength was 5/5. Given his lack of significant weakness, was "hopeful he just strained something and has developed subacromial inflammation due to the suture material and scar tissue." An MRI was ordered.

01/08/14: MRI Right Shoulder report. IMPRESSION: Postsurgical changes are appreciated within the shoulder including evidence of rotator cuff reconstruction and acromioplasty. Glenohumeral joint effusion and subacromial-subdeltoid bursitis. Intermediate increase in signal is present within the distal supraspinatus and infraspinatus tendons compatible with postsurgical change and/or tendinosis. There are no full-thickness rotator cuff tears.

01/17/14: The claimant was evaluated. On exam of the right shoulder, impingement signs were positive. A painful arc was present between 90 and 130 degrees. Mild weakness of abduction. Range of motion was well preserved. It was opinion that rotator cuff inflammation was his primary pain generator. It was noted that at that point he had "numerous injections, physical therapy, and tincture of time." recommended an arthroscopic evaluation of the shoulder, diagnostically with subacromial bursectomy, and resection of suture material and scar tissue.

01/28/14: UR. RATIONALE: The MRI dated 01/08/14 reveals postsurgical changes appreciated within the shoulder including evidence of rotator cuff reconstruction and acromioplasty. Glenohumeral joint effusion and subacromial subdeltoid bursitis is noted and there is intermediate increase in signal present within the distal supraspinatus and infraspinatus tendons compatible with postsurgical changes and/or tendinosis. There are no full thickness rotator cuff tears identified on that exam. No residual sources for rotator cuff impingement were present on that exam. The last clinical exam of 01/17/14 noted that impingement signs were positive to the right shoulder and he has painful arc present between 90 and 130 degrees with mild weakness of abduction and range of motion is preserved. Physical findings do not correlate with the imaging studies as recommended by guidelines. No evidence of partial or full thickness rotator cuff tear evidence and there is no evidence of impingement by imaging. The records do not indicate that there is evidence of a lesion for which glenohumeral joint debridement would be necessary and there is no evidence of significant synovectomy. Assistant surgeon is not considered reasonable and necessary at this point in time. Therefore, the request is not considered medically necessary in totality and is non-certified.

02/06/14: Letter. "I have been treating for a musculoskeletal problem involving his right shoulder. He injured his right shoulder on xx/xx/xx. His is a long and complicated case. He had a sharp pain [in the] shoulder radiating down the arm. His neck became fairly stiff and he developed tremendous pain in the shoulder. He continued to work and eventually sought medical care. He was evaluated MRI was obtained. He tried to continue working he had the same pain. He tried exercises and physical therapy but his symptoms did not improve. MRI disclosed a high-grade partial thickness rotator cuff tear. Surgery was eventually recommended. On October 3, 2007, I performed rotator cuff repair. He had appropriate rehabilitation following the surgery. He was released to full duty work and reached maximum medical improvement in 2008. He had a recurrence of symptoms without any new injury in 2010. I performed a subacromial injection, which did give him temporary improvement in his symptoms. It was noted on x-rays that he had redeveloped a distal clavicle spur, and it was felt that the spur was causing irritation of the rotator cuff. I subsequently recommended a second surgery. On April 27, 2011, I performed an arthroscopic resection of adhesions, removal of the distal clavicle spur and removal of suture material from the previous surgery. He got complete relief from surgery. He underwent appropriate rehabilitation after the procedure. He did well until May 2012 when his symptoms recurred. An MRI was obtained on June 8, 2012. A partial rotator cuff tear was found and the biceps was found to be hypertrophied. Multiple subacromial injections and therapy were tried. On August 8, 2012, I performed a revision rotator cuff repair and tenotomy of the long head of the biceps tendon. He underwent postsurgical physical therapy and made very good progress. He was subsequently released to a home exercise program in March 2013 and was doing very well. I did not see him again until November 2013. He reported that he developed right shoulder pain in August without any specific injury. He had undergone a cortisone injection by his pain management doctor, which did give him improvement in his symptoms. He subsequently underwent MRI on January

8, 2014. Postsurgical changes were seen without evidence of rotator cuff retear. It is my opinion after examining him that subacromial inflammation is causing his current symptoms. I have recommended a diagnostic arthroscopy with likely debridement, subacromial bursectomy, and resection of adhesions and removal of any loose suture material. This was non-certified by the carrier citing a peer review. Please let this serve as a formal reconsideration. He has gotten temporary improvement with a subacromial injection, and I do think he would benefit from arthroscopy.”

03/07/14: UR. RATIONALE: The request was previously denied since physical findings did not correlate with the imaging studies and the surgery was not authorized to warrant an assistant surgeon. There is an updated documentation submitted for review including a recent medical record dated 02/06/14. A prior history of right shoulder rotator cuff repair and biceps tenotomy in 10/2007 was noted. He underwent arthroscopic resection of adhesions with removal of distal clavicle spur and suture material on 04/27/11 and rotator cuff repair and biceps tenotomy on 08/08/12. The patient was treated with medications, corticosteroid injection, home exercises, and physical therapy visits which provided some relief. MRI of the right shoulder dated 01/08/14 showed postsurgical changes appreciated with the shoulder including evidence of rotator cuff reconstruction and acromioplasty, glenohumeral joint effusion, and subacromial/subdeltoid bursitis. On 01/17/14 followup, he complained of right shoulder pain. Physical examination on that visit showed positive impingement signs. There was a painful arc between 90 and 130 degrees. There was mild abduction weakness. The appeal letter dated 02/06/14 indicates that the patient continues to experience pain in the right shoulder. It was opined by the provider that subacromial inflammation is causing his current symptoms. It was also noted that the patient followed up on 11/2013 in which he reported recurrence of right shoulder pain. He was eventually treated with corticosteroid injection. While the patient complains of right shoulder pain, there was no evidence in the medical reports submitted that the patient has exhausted conservative treatment for this recurrence including physical therapy prior to the proposed surgery. There is a request for an assistant surgeon. However, the requested surgery must be duly authorized as deeming appropriate and necessary in which the medical records submitted failed to support this yet. In agreement with the previous determination, the medical necessity of the request has not been substantiated.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decisions are partially overturned. The ODG requirements for surgery have been met. The claimant has had conservative management without long-term relief, including physical therapy and injections. He has had numerous surgeries, which could interfere with MRI findings. He has signs and symptoms of significant impingement, bursitis, and tenosynovitis on exam, including painful arc between 90 and 130 degrees, and weakness of abduction. He has pain and positive impingement sign with temporary relief of pain with injection. Therefore, the request for right shoulder arthroscopic subacromial decompression, right shoulder arthroscopic glenohumeral debridement, right

shoulder arthroscopic synovectomy, complete, and right shoulder mini-open rotator cuff repair is medically necessary. However, the assistant surgeon is not found to be medically necessary.

ODG:

Surgery for impingement syndrome	<p><u>ODG Indications for Surgery™ -- Acromioplasty:</u> Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS 2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS 3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS 4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. (Washington, 2002)</p>
Surgery for rotator cuff repair	<p><u>ODG Indications for Surgery™ -- Rotator cuff repair:</u> Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out: 1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS 2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS 3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS 2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS 3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS 4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. (Washington, 2002) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>

ODG does not specifically discuss assistant surgeon.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL &
ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY
GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR
GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW
BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN
ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &
PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**